Preliminary Review

of the

Feasibility of a Missouri Health Care Stabilization Fund

Submitted by:

Health Care Stabilization Fund Feasibility Board

January 24, 2008

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I. Background of Review

In 2006, the General Assembly passed and Gov. Matt Blunt signed House Bill 1837. This legislation's intent focused on monitoring the stability of the medical malpractice insurance market in Missouri by providing the Department of Insurance, Financial Institutions and Professional Registration (DIFP or department) access to certain medical malpractice insurance market data to assist medical malpractice insurers in developing future rates and rating criteria and by broadening some components of the department's regulatory oversight of the insurers. The bill also created the Health Care Stabilization Fund Feasibility Board. (See attached § 376.250 RSMo, 2006**).**

The board was created to "determine whether a health care stabilization fund should be established in Missouri to provide excess medical malpractice insurance coverage for health care providers". The need for a health care stabilization fund is to be evaluated for the entire state, for specific geographic areas, or for specific medical specialties.

A health care stabilization fund essentially provides excess professional liability coverage for health care providers. Typically funded by a surcharge on premiums or other types of fees imposed on providers; the state creates a fund that pays for a portion of a judgment or settlement arising from a claim against a health care provider. The fund serves as an excess layer of coverage, which is initiated when the provider's projected loss exposure, is greater than a stipulated threshold. The amount below the threshold is covered by the provider's primary insurance policy. Participation in the fund can either be voluntary or mandatory, depending on state law. While some funds have a monetary cap per occurrence and an annual aggregate limit, others provide unlimited coverage for medical expenses. A health care stabilization fund may provide stability in the medical malpractice market by targeting payment or coverage at the high end of the claim distribution spectrum.

II. Board Members

The board consists of 10 members. The director of DIFP is a member and he appointed five other members as directed by statute. Two members of the senate were appointed by the president pro tem, and two members of the house were appointed by the speaker of the house.

The 10 members of the board include:

1. Senator Bill Stouffer, Chairman
2. Senator Victor Callahan
3. Representative Rob Schaaf
4. Representative Curt Dougherty
5. John Stanley, MD, representing family physicians
6. Steve Reintjes, MD, representing medical doctors
7. Lancer Gates, DO, representing osteopathic doctors
8. Gloria Solis, RN MSN, MBA representing nurses
9. David Carpenter, representing Missouri hospitals
10. Doug Ommen, Director of DIFP/or his designee

III. Board Mission

By 2010, the board is required to conduct a comprehensive study of whether a health care stabilization fund is feasible and is an appropriate solution to stabilize the affordability and availability of medical malpractice insurance in Missouri. The board is evaluating whether a stabilization fund may be needed in the entire state, in a specific region of the state or for certain medical specialties (such as neurological surgeons and/or obstetrician-gynecologists). In carrying out their charge, the board is directed to analyze medical malpractice claims, base rates, actual premiums charged, loss exposure, etc. The board may also study the experiences of other states such as Kansas which established a health care stabilization fund in 1976. Finally, if the board determines that a health care stabilization fund is necessary, it will make recommendations as to how the fund could be structured, designed and funded.

IV. Board Meetings

The board met quarterly as required by law. The board meetings took place in March, June, September and December in 2007. Meetings were held in compliance with §§610.010-610.200 RSMo, 2006, in Kansas City at various locations, since a majority of the board members

are from that area. The final approved minutes for each meeting are posted on the following Web site: www.senate.mo.gov/05info/comm/interim/jchc.htm

V. Focus of Review

Board members discussed the information needed to determine if a health care stabilization fund would be beneficial to the medical malpractice market in Missouri. Before such things as costs, plan design, or efficacy of a fund are examined, the board needs to determine whether the fund is even necessary. While there are a number of questions that need to be addressed, the board's primary focus is in three areas:

- Will a stabilization fund affect the number of doctors practicing in MO?
- What effects would a health care stabilization fund have on doctors and their practices?
- Will a fund provide stability to the availability and pricing of medical malpractice insurance?

Other pertinent questions include:

- How many active doctors are practicing in Missouri and where are they located?
- How many doctors are independently employed? How many are employed by hospitals? Does the employment reflect any regional patterns?
- Where are doctors currently purchasing their medical malpractice insurance? How many are insured by commercial insurers? By surplus lines insurers? By hospital plans? How many are self-insured? How many doctors practicing in Missouri are insured through the KS Stabilization Fund?
- Do specialists pay different premiums by geographic area?
- Is there a change in the number of practicing doctors in Missouri? Does this change reflect any regional patterns? Are these patterns being caused by medical malpractice insurance cost and availability? Are there any other things influencing these patterns?
- What is the impact of the 2005 Tort Reform on medical malpractice insurance?
- In a comparison of medical malpractice premiums between Kansas and Missouri, how much of the cost difference is because of the Kansas stabilization fund? The tort differences? The difference in the number of doctors? The difference in the cost of providing healthcare? The difference in the propensity of patients to file a claim?

- How many Missouri doctors want a stabilization fund in Missouri? Is the finding regional? Is the finding based on certain specialties? Should a pilot program be implemented?
- Will the stabilization fund save doctors money on insurance premiums?
- What is the current state of affairs for the medical malpractice insurance market in Missouri?
- Will the changes from HB 1837 (2006) affect the medical malpractice insurance market? If so, how?

The board has attempted to obtain answers to these questions. There is limited verifiable information on the distribution and movement of practicing doctors in Missouri, where doctors are buying their malpractice insurance, and how much they are paying. Additionally, a minimum amount of statewide data is available for insurers to use in determining their risk exposure which is used to calculate premium. The board unanimously agrees that the more data insurers have, the better job they will do in estimating their premium need. It is also clear that some of these questions cannot be answered by this board. However, it is important to note that merely asking these questions may provide some guidance in determining whether a stabilization fund would benefit Missouri's market.

To establish if there are any shortages of doctors in specific regions within Missouri, it is important to know the total number of doctors and where they are located. There is a perception that many doctors left the state around 2002 due to the rising cost of medical malpractice insurance, but at this time, there seems to be only anecdotal, incomplete and inaccurate information regarding this claim. There is an assertion that there has been a shift in the number of licensed doctors practicing in Missouri and where they are practicing, however, identifying if a shift has actually occurred or what may have caused it is largely unknown. . For example, doctors could have moved to another state, or they could have retired, quit practicing, or they may have passed away. We do not have accurate and reliable data on which we can evaluate patterns of movement or practice changes by doctors.

If doctors did move out of Missouri, was it because of the affordability and availability of medical malpractice insurance or was it for some other reason? Without the ability to identify and survey doctors who have moved out of Missouri, the board must work with the information that is available. DIFP collects some data necessary to evaluate the current state of practicing

medical professionals. The Division of Professional Registration collects information on the physician license renewal application but that provides limited information on the distribution of doctors and it does not consistently provide a medical specialty or whether a doctor is practicing full-time part-time or is retired. All of this is necessary information to conduct a thorough study.

Additionally, an analysis of tort reform (§538.210 RSMo, 2006) and its impact on the medical malpractice insurance market is needed. The degree to which the impact can be evaluated will be driven by the availability of data relevant to tort reform and statistical constraints on the analysis of the data. There may not yet be sufficient information available to determine if tort reform was enough to stabilize the medical malpractice market, or if something more needs to be done. The outcome of court challenges to the tort reform may ultimately affect any impact tort reform may have on the medical malpractice market.

With the passage of HB 1837 (2006), the board expected medical malpractice insurers would be submitting most, if not all, of the important and relevant medical malpractice insurance data to DIFP for analysis (§§383.105, and 383.106 RSMo, 2006). Members of the board thought that this data would provide annual information on the number of doctors insured in the commercial market, actual premium amounts paid, as well as the detailed data components that would allow DIFP to compile a statewide risk analysis database available to all medical malpractice insurers for use in pricing their coverage. Additionally, the bill was expected to provide the department with the authority needed to enhance regulatory oversight of medical malpractice insurance rating practices. (§§383.203, and 383.206 RSMo, 2006).

The objections raised by a few insurers at JCAR regarding the interpretation of the bill's language significantly delayed the department's efforts to enforce data collection. These complaints include data confidentiality concerns as well as some arguments regarding the types of data to be collected. On the recommendation of the Joint Committee on Administrative Rules (JCAR), the department has withdrawn nine proposed rules filed with the Secretary of State since April 2007. As quickly as possible, revisions need to be made to the laws contained in HB 1837 (2006) to enhance confidentiality of the data collection and clarify the data elements to be collected, so that DIFP can collect the data necessary to evaluate the current condition of the medical malpractice market in Missouri and assist insurers in calculating accurate premiums for Missouri doctors. The rate regulation provisions found at §383.206 RSMo, may need to be reviewed as well to determine the original intent of the law. It is unclear if the intent was to

provide the department with greater authority in this area or not. The language of those statutes should be clarified so that there is no misunderstanding as to what was intended with the passage of these laws.

Insurers are reporting base rate information on medical malpractice insurance to DIFP as required by HB1837. This information has limited value and was previously provided to the department in the insurer's rate filings.

VI. Current Recommendations

1. The General Assembly should take **immediate** action to make corrections to §§ 383.105 and 383.106 RSMo, to enhance the confidentiality of the data and assure the laws are clear as to what types of data need to be reported to DIFP from the current medical malpractice market in Missouri. These changes should have an effective date as soon as can practicably be implemented by DIFP. (See Appendix A)
2. The General Assembly should recommend that the Board of Healing Arts take steps to enhance the information reported by doctors on the annual license renewal form submitted to DIFP, Division of Professional Registration (PR). At a minimum, this enhanced information should identify where they are practicing, their specialty, whether they are working part-time, full-time, or are retired, and how they are insured for medical malpractice. The necessary funding for this enhanced reporting and analysis thereof should also be made available to the appropriate state agency. The information collected on the license renewal should remain confidential but should be shared with other state agencies and state entities, such as DIFP, DHSS and the HCSFFB as needed. (See Appendix B)
3. Certain information or data elements already received by PR should be allowed, with appropriate protections, to be shared with DIFP, DHSS (because the information is used for the determination of shortage areas) and the HCSFFB. Funding should be provided for entering the historically reported information into an electronic database, so the information can be analyzed and assist in providing answers to questions that presently can only be answered with inaccurate and incomplete information.

4. The General Assembly should provide funds for a study by an independent actuarial firm to evaluate the impact of the 2005 Tort Reform on claims activity A separate study should determine whether doctors are moving from Missouri and if so, what factors might be influencing those moves.

At this time, the board is not able to make an informed decision about the need and potential benefits of a health care stabilization fund without additional data. The board must make a final recommendation by 2010 and with approval of these interim recommendations, members will be better positioned to make an informed recommendation based on complete and accurate knowledge of the medical malpractice market in Missouri.

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VII. Appendix A

AN ACT

To repeal sections 383.100, 383.105, 383.106, 383.107 and 383.108, RSMo, and to enact in lieu thereof five new sections relating to medical malpractice insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 383.100, 383.105, 383.106, 383.107 and 383.108, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 383.100, 383.105, 383.106, 383.107 and 383.108, to read as follows:

383.100. As used in sections 383.100 to 383.108, RSMo, the following terms mean:

1. "Director**", [**the director shall be**]** the director of the department of insurance**, financial institutions and professional registration**;

2. "Health care provider**", [**includes**]** physicians, dentists, clinical psychologists, pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors, physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals, nursing homes and extended care facilities; but shall not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination;

3. "Medical malpractice insurance", **[**means**]** insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of the negligence or malpractice in rendering professional service by any health care provider.

4. "Insurer", every insurance company authorized to transact insurance business in this state, every unauthorized insurance company transacting business pursuant to chapter 384, RSMo, every risk retention group, every insurance company issuing insurance to or

through a purchasing group, every entity operating under this chapter, and any other person providing insurance coverage in this state, including self-insured health care providers.

383.105. 1. Every insurer providing medical malpractice insurance to a Missouri health care provider and every health care provider who maintains professional liability coverage through a plan of self-insurance shall submit to the director a report of all claims, both open claims filed during the reporting period and closed claims filed during the reporting period, for medical malpractice made against any of its Missouri insureds during the preceding three-month period.

2. The report shall be in writing and contain the following information:

(1) Name and address of the insured and the person working for the insured who rendered the service which gave rise to the claim, if the two are different;

(2) Specialty coverage of the insured;

(3) Insured's policy number;

(4) Nature and substance of the claim;

(5) Date and place in which the claim arose;

(6) Name, address and age of the claimant or plaintiff;

(7) Within six months after final disposition of the claim, the amounts paid, if any, and the date and manner of disposition (judgment, settlement or otherwise);

(8) Expenses incurred; and

(9) Such additional information as the director may require.

3. **[**As used in sections 383.100 to 383.125, "insurer" includes every insurance company authorized to transact insurance business in this state, every unauthorized insurance company transacting business pursuant to chapter 384, RSMo, every risk retention group, every insurance company issuing insurance to or through a purchasing group, every entity operating under this chapter, and any other person providing insurance coverage in this state, including self-insured

health care providers.**]** **Such reports shall be made to the director quarterly on dates and in the form prescribed by the director.**

4. Information submitted pursuant to section 383.105.2, subdivisions (1), (3) and (6), RSMo, shall be deemed to be confidential communication except as provided in section 383.105.5. RSMo.

5. The director shall, upon receipt, submit in writing the pertinent and appropriate data and information submitted pursuant to section 383.105.2, RSMo, to the applicable health care licensing board. The director shall also submit a report containing the information described in section 383.105.2(3)-(8), RSMo, to the director of the department of social services or the director the department of social services' designee. Information shall be disclosed to the department of social services so that the department of social services can determine whether the claimant or plaintiff was concurrently enrolled in the MO HealthNet program during the period in which the alleged incident occurred. The information provided to the department of social services shall be subject to the confidentiality restrictions provided by sections 208.217.7 and 383.105, RSMo.

383.106. 1. To effectively monitor the insurance marketplace, rates, financial solvency, and affordability and availability of medical malpractice coverage, the director shall establish by rule or order reporting standards for insurers by which the insurers, or an advisory organization designated by the director, shall annually report such Missouri medical malpractice insurance premium, loss, exposure, and other information as the director may require.

2. **[**The director shall, prior to May 30, 2007, establish risk reporting categories for medical malpractice insurance, as defined in section 383.150, and shall establish regulations for the reporting of all base rates and premiums charged in those categories as determined by the director. The director shall consider the history of prior court judgments for claims under this chapter in each county of the state in establishing the risk reporting categories.**] Data shall include, but not be limited to**

a. written and earned premium at filed base rates

b. written and earned premium

c. written and earned exposures

d. paid and incurred losses

e. paid and incurred loss adjustment expenses

f. assessments

g. reserves

h. open and closed claims

i. cancellations and non-renewals

j. new policies issued.

3. The data required by this section shall be reported in accordance with a uniform classification system developed by the director. Classes may include, but not be limited to, type of coverage or policy, policy limits, other relevant policy characteristics, county of practice, medical specialty class, individual risk rating factors and claim history. To the extent practical, the director shall utilize existing industry medical specialty classes, such as those developed by the Insurance Services Office (ISO).

[3**] 4**. The director shall **[**collect**] compile** the information **[**required**] collected** in this section **[**and compile it**]** in a manner appropriate for assisting Missouri medical malpractice insurers in developing their future base rates, schedule rating, or individual risk rating factors and other aspects of their rating plans. In compiling the information and making it available to Missouri insurers and the public, the director shall remove any individualized information that identifies a particular insurer**, defendant, plaintiff, or other party to a malpractice action [**as the source of the information**]**. The director may combine such information with similar information obtained through insurer examinations so as to cover periods of more than one year.

[4. All insurers with regards to medical malpractice insurance as defined in section 383.150 shall provide to the director, beginning on June 1, 2008, and not less than annually

thereafter, an accurate report as to the actual rates, including assessments levied against members, charged by such company for such insurance, for each of the risk reporting categories established under this section.**]**

5. To ensure that sensitive information such as individual identities cannot be inferred from information collected pursuant to 383.106, RSMo, either directly or indirectly in combination with other public information, all collected information and data derived from such information is confidential information and is not discoverable or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding, nor may any of it be released by the director to the public unless the data meets each of the following criteria:

a. The threshold rule: non-zero data cells or totals must include a minimum of five observations;

b. The p-percent rule: the sum of all but the largest three observations in a data cell or total must be less than a specified percent of the largest value, such that

$$\sum_{i=c+2}^{N} X_i \geq p \times X_1$$

***c* is the second and third largest observations;**

c+2 represents all observations but the largest three;

N is the total number of observations in a data cell; and

***p* represents a percent less than 100.**

c. The (n,k) rule: no single observation can exceed a specified percent (k) of a data cell total.

d. The values for each of the three preceding criteria shall be calculated in accordance with the methods prescribed in the *Statistical Policy Working Paper 22 (Second version, 2005), Report on Statistical Disclosure Limitation Methodology,* Federal Committee on Statistical Methodology, Office of Management and Budget.

e. The value of the parameter *p* in the p-percent rule, and of *k* in the (n,k) rule shall be determined by the director. As prescribed in the *Statistical Policy Working Paper 22,* to lessen the likelihood that public malpractice data can be used to infer individual identities and other sensitive information, the value of these parameters shall be considered propriety and confidential, and immune from requests made pursuant to chapter 610, RSMo; nor shall such information be discoverable or admissible in any legal proceeding.

6. Except as expressly permitted, all data collected pursuant to this section shall be considered proprietary and confidential, and immune from requests made pursuant to chapter 610, RSMo; nor shall such information be discoverable or admissible in any legal proceeding. The confidentiality created herein is a matter of substantive law of this state and is not merely a procedural matter governing civil or criminal procedures in the courts of this state.

7. To ensure the integrity of the confidentiality of this information, the director, the director of insurance market regulation and all employees of the department and its divisions shall be bound to keep secret all information obtained under this section, except as authorized upon a finding by the director that the criteria in this section have been met. If any employee of the department discloses to a non-employee of the department any confidential information without the authority of the director, the disclosing person shall be deemed guilty of a class B misdemeanor.

383.107. Not later than December 31, 2009, and at least annually thereafter, the director shall, utilizing the information provided pursuant to section 383.106, **RSMo, [**establish and**]** publish a market rate reflecting the **[**median**] average** of the actual rates charged for each of the **[**risk reporting categories**] medical specialties in the uniform classification system** for the preceding year **[**by all insurers with at least a three percent market share of the medical malpractice insurance market as of December thirty-first of the prior year, which are certified to

have rates which are not inadequate by an actuary selected and approved by the director**]**. **Rates for each class shall be calculated as the ratio of written premium to written exposures.**

383.108.1. Beginning September 30, 2008, and annually thereafter, all insurers actively writing medical malpractice insurance shall submit base rates to the director in accordance with the uniform classification system developed pursuant to section 383.106, RSMo. Surplus lines insurers, risk retention groups and self insureds are not required to submit base rates in accordance with this section.

2. If an insurer modifies its base rates between annual base rate filings the insurer shall notify the director within thirty (30) days after such base rate modification is effective. Such notification shall be in the form and manner prescribed by the director.

3. No later than January 1, 2009, and annually thereafter, the director shall, utilizing the information submitted pursuant to sections 383.106 and 383.108, RSMo, publish comparisons of the base rates charged by each insurer actively writing medical malpractice insurance.

[383.108. The director shall, utilizing the information provided under section 383.106, publish comparisons of the base rates charged by each insurer actively writing medical malpractice insurance.**]**

VIII. Appendix B

RECOMMENDATIONS FOR ADDITIONS TO THE PHYSICIAN LICENSE AND RENEWAL DOCUMENTS

PLEASE ANSWER FOR JANUARY 1 OF THE LICENSE RENEWAL YEAR.

1. Residence information:
   Primary residential address _____
   _____
   _____

   Mailing Address (if different from above) _____
   _____
   _____

2. Practice location information: Please list your business address below. If multiple addresses exist, please indicated percentage of time served at each location

   a. _____ 100% ___ 33%___
   _____ 75% ___ 25% ___
   _____ 50% ___ less than 25% __

   b. _____ 100% ___ 33% ___
   _____ 75% ___ 25%___
   _____ 50% ___ less than 25% __

   c. _____ 100% ___ 33% ___
   _____ 75% ___ 25%___
   _____ 50% ___ less than 25%___

3. Are you actively practicing medicine in the State of Missouri?

   _____Yes, Full-time (40+ hours/week in Missouri)

   _____Yes, Part-time (20-39 hours/week in Missouri)

   _____Yes, Less than 20 hours/week in Missouri

   _____No, Retired. Indicate year of retirement: _____

   _____No, Choose a Reason:

   _____Working in Another Field

   _____Active in Another State

   _____Homemaker

   _____In Professional Training

   _____No, Indicate other reason: _____

4. Please indicate the type of medical malpractice (medical professional liability) insurance that best describes your current situation when you practice in Missouri:

   _____I am practicing medicine and I am uninsured for medical malpractice claims.

   _____I am not currently practicing medicine and I have no coverage for my prior medical practice.

   _____I am not currently practicing medicine but I have coverage for my prior medical practice.

   _____I purchase an individual policy from an insurance company and my deductible is less than or equal to $10,000.

   _____I purchase an individual policy from an insurance company and my deductible is more than $10,000.

   _____I am a resident of Kansas and participate in the Kansas Health Care Stabilization Fund for my practice in Missouri.

   _____I am insured as an owner or partner under a policy purchased by or for the group.

   _____My employer provides insurance coverage or covers me through a program of self-insurance.

   _____Other. Please describe _____.

SELECT CODE NUMBERS FROM CODE SHEET
The attached specialty codes are from "**ABMS, AOA, or Podiatric Specialty/Subspecialty code".** The organization keeps the codes up to date and provides instructions as to the meaning of the medical specialty. The state may need permission to use the codes.

(Select from Codes 10-24)

5. TYPE OF EMPLOYMENT: _____If other, specify_____

(Select from Codes 50-72)

6. SETTING OF EMPLOYMENT: _____If other, specify_____

7. SPECIALTIES: (If specialty not listed alphabetically, use 000 and specify specialty.)

   Primary_____ If 000, specify _____Board Certified? Yes_____ No_____
   Major Surgery_____, Minor Surgery only_____, No Surgery_____

   Secondary _____ If 000, specify _____Board Certified? Yes_____ No_____
   Major Surgery_____, Minor Surgery only_____, No Surgery_____

CODE SHEET

Please select a two-digit number from the Type of Employment and Setting of Employment codes and place in the Type and Setting of Employment sections on page two of the renewal form.

TYPE OF EMPLOYMENT (Question 5)

(Select only one form of employment)

Self Employment
- 10 Solo practice
- 11 Partnership or group owned practice
- 12 Locum tenens

Nongovernmental Employee of
- 13 Individual practitioner
- 14 Partnership or group of practitioners
- 15 Group health plan
- 16 Other nongovernmental employer (Specify)

Governmental Employee
- 17 Local government (other than county or state)
- 18 County government
- 19 State government
- 20 Federal government (USPHS and civilians other than VA)
- 21 Federal government (Armed forces personnel only)
- 22 Federal government (VA)

Other Forms of Employment
- 23 Unpaid voluntary worker
- 24 Other (Specify)

SETTING OF EMPLOYMENT (Question 6)

(Select only one place of activity)

Nonfederal Health Facility
- 50 Hospital (other than mental)
- 51 Mental hospital
- 52 Nursing home
- 53 Clinic, free standing
- 54 Group health plan facility
- 55 Practitioner's office
- 56 Hospital and office

Federal Health Facility
- 57 Health facility on military installation
- 58 VA
- 59 Public health, Indian health, and civilian other than VA

School
- 60 School of medicine or dentistry
- 61 School of nursing
- 62 University or college other than medical, dental, or nursing
- 63 School or treatment center for the handicapped or disabled
- 64 Residency training program
- 65 Other schools (specify)

Miscellaneous Places
- 66 Patients' homes
- 67 Medical research institution or establishment
- 68 Professional or allied health association
- 69 Administrative or regulatory health agency
- 70 Manufacturing or industrial establishment
- 71 Retail, wholesale, or other business establishment

Other Settings of Employment
- 72 Other (Specify)

SPECIALTY CODES (Question 7)

Please select an approved ABMS, AOA, or Podiatric Specialty/Subspecialty code and place in the Occupational Specialty section on page two of the renewal form. If specialty not listed, please specify in "Unlisted Specialty".

- 01 ADOLESCENT MEDICINE
- 02 AEROSPACE MEDICINE
- 03 ALLERGY AND IMMUNOLOGY
- 04 ANESTHESIOLOGY
- 05 BLOOD BANKING/TRANSFUSION MEDICINE
- 06 CARDIAC ELECTROPHYSIOLOGY
- 07 CARDIOLOGY
- 08 CARDIOVASCULAR DISEASE
- 09 CHEMICAL PATHOLOGY
- 10 CLINICAL BIOCHEMICAL GENETICS
- 11 CLINICAL BIOCHEMICAL/MOLECULAR GENETICS
- 12 CLINICAL CYTOGENETICS
- 13 CLINICAL GENETICS (M.D.)
- 14 CLINICAL & LAB DERMATOLOGICAL IMMUNOLOGY
- 15 CLINICAL & LABORATORY IMMUNOLOGY
- 16 CLINICAL MOLECULAR GENETICS
- 17 CLINICAL NEUROPHYSIOLOGY
- 18 CRITICAL CARE MEDICINE
- 19 CRITICAL CARE SURGICAL
- 20 CYTOPATHOLOGY
- 21 DERMATOLOGY
- 22 DERMATOPATHOLOGY
- 23 EMERGENCY MEDICINE
- 24 ENDOCRINOLOGY
- 25 ENDOCRINOLOGY, DIABETES & METABOLISM
- 26 ENDOCRINOLOGY, REPRODUCTIVE
- 27 FAMILY PRACTICE
- 28 GASTROENTEROLOGY

29 GENERAL PRACTICE
30 GERIATRIC MEDICINE
31 GYNECOLOGIC ONCOLOGY
32 HEMATOLOGY
33 HEMATOLOGY AND ONCOLOGY
34 IMMUNOPATHOLOGY
35 INFECTIOUS DISEASE
36 INTERNAL MEDICINE
37 LABORATORY MEDICINE
38 MATERNAL AND FETAL MEDICINE
39 MEDICAL DISEASES OF THE CHEST
40 MEDICAL GENETICS
41 MEDICAL MICROBIOLOGY
42 MEDICAL ONCOLOGY
43 MEDICAL TOXICOLOGY
44 NEONATAL-PERINATAL MEDICINE
45 NEONATOLOGY
46 NEPHROLOGY
47 NEUROLOGY
48 NEUROLOGY, CHILD
49 NEUROLOGY AND PSYCHIATRY
50 NEUROPATHOLOGY
51 NEURORADIOLOGY
52 NUCLEAR MEDICINE
53 NUCLEAR RADIOLOGY
54 OBSTETRICS AND GYNECOLOGY
55 OCCUPATIONAL MEDICINE
56 ONCOLOGY
57 OPHTHALMOLOGY
58 OTOLARYNGOLOGY
59 OTOLOGY/NEUROTOLOGY
60 OTORHINOLARYNGOLOGY
61 PAIN MANAGEMENT
62 PATHOLOGY, ANATOMIC
63 PATHOLOGY, ANATOMIC/CLINICAL
64 PATHOLOGY, ANATOMIC AND LAB MEDICINE
65 PATHOLOGY, CLINICAL
66 PATHOLOGY, FORENSIC
67 PEDIATRICS
68 PEDIATRIC ALLERGY & IMMUNOLOGY
69 PEDIATRIC CARDIOLOGY
70 PEDIATRIC CRITICAL CARE MEDICINE
71 PEDIATRIC EMERGENCY MEDICINE
72 PEDIATRIC ENDOCRINOLOGY
73 PEDIATRIC GASTROENTEROLOGY
74 PEDIATRIC HEMATOLOGY-ONCOLOGY
75 PEDIATRIC INFECTIOUS DISEASE
76 PEDIATRIC INTENSIVE CARE
77 PEDIATRIC NEPHROLOGY
78 PEDIATRIC NEUROLOGY
79 PEDIATRIC OTOLARYNGOLOGY
80 PEDIATRIC PATHOLOGY
81 PEDIATRIC PSYCHIATRY
82 PEDIATRIC PULMONOLOGY
83 PEDIATRIC RADIOLOGY
84 PEDIATRIC RHEUMATOLOGY
85 PEDIATRIC SPORTS MEDICINE
86 PHYSICAL MEDICINE AND REHABILITATION
87 PODIATRIC MEDICINE
88 PODIATRIC ORTHOPAEDICS
89 PODIATRIC SURGERY
90 PREVENTIVE MEDICINE/AEROSPACE MEDICINE
91 PREVENTIVE MEDICINE/OCCUPATIONALENVIRONMENTAL MEDICINE
92 PREVENTIVE MEDICINE/OCCUPATIONAL M EDICINE
93 PROCTOLOGY
94 PSYCHIATRY
95 PSYCHIATRY, ADDICTION
96 PSYCHIATRY, CHILD
97 PSYCHIATRY, CHILD AND ADOLESCENT
98 PSYCHIATRY, FORENSIC
99 PSYCHIATRY, GERIATRIC
100 PUBLIC HEALTH & GEN PREVENTIVE MEDICINE
101 PULMONARY DISEASE
102 PULMONARY MEDICINE
103 RADIATION ONCOLOGY
104 RADIATION THERAPY
105 RADIOLOGICAL PHYSICS
106 RADIOLOGY
107 RADIOLOGY, DIAGNOSTIC
108 RADIOLOGY, VASCULAR AND INTERVENTIONAL
109 REHABILITATION MEDICINE
110 RHEUMATOLOGY
111 ROENTGENOLOGY
112 ROENTGENOLOGY, DIAGNOSTIC
113 SPECIAL PROFICIENCY IN OSTEOPATHIC MANIPULATIVE MEDICINE
114 SPINAL CORD INJURY MEDICINE
115 SPORTS MEDICINE
116 SURGERY
117 SURGERY, COLON AND RECTAL
118 SURGERY, FACIAL PLASTIC
119 SURGERY, GENERAL
120 SURGERY, GENERAL VASCULAR
121 SURGERY, HAND
122 SURGERY, NEUROLOGICAL
123 SURGERY, OBSTETRICS/GYNECOLOGIC
124 SURGERY, ORTHOPAEDIC
125 SURGERY, OTORHINOLARYNGOLOGY AND FACIAL PLASTIC
126 SURGERY, PEDIATRIC
127 SURGERY, PLASTIC
128 SURGERY, PLASTIC AND RECONSTRUCTIVE
129 SURGERY, THORACIC
130 SURGERY, THORACIC CARDIOVASCULAR
131 SURGERY, UROLOGICAL
132 UNDERSEA MEDICINE
133 UROLOGY
UNLISTED SPECIALTY:
000 OTHER (SPECIFY)